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# Nursing students' perceptions of patient dignity

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**Abstract**

**Background:** Respecting patients' dignity has been described as a fundamental part of nursing care. Many studies have focused on exploring the concept of patients' dignity from the patient and nurse perspective, but knowledge is limited regarding students' nursing perceptions and experiences.

**Objective:** To explore the issue of patients' dignity from the perspective of nursing students.

**Research design:** A qualitative study was employed with the formation of four focus groups and the participation of nursing students. Data were analysed via a thematic content analysis of the discussions.

**Participants and research context:** Thirty-four nursing students of a Cyprus University participated in the four focus groups. Each group was homogenous in terms of the year of study and heterogeneous in terms of clinical practice in various wards.

**Ethical consideration:** The study's protocol was reviewed and approved by the Cyprus National Bioethics Committee. Ethical standards were followed throughout the study.

**Findings:** Several factors that maintain or compromise patients' dignity emerged. These factors were grouped into five themes: (a) patients' preferences, verbal abuse and regarding a patient as a unique person; (b) privacy and confidentiality; (c) loss of autonomy and need for help; (d) discrimination and (e) attribution and reciprocity.

**Discussion:** Different understandings of the perceived concept of dignity and the factors that maintain or compromise patient's dignity were expressed through the eyes and the feelings of nursing students. Students highlighted the importance of promoting patient dignity as an important component of nursing care.

**Conclusion:** Nurse educators can use the findings of this study in order to tailor nursing programmes to emphasise the importance of respecting patients' dignity. In addition, nurse ward managers can use the findings as means for persuading nurses to change current behaviour.

**Keywords**
Dignity, focus groups, nursing care, nursing students

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## Introduction

Respect of human dignity is recognised by national and international organisations (e.g. European Union and International Council of Nurses). It is conceived as an essential component and is acknowledged as a core attribute of nursing care.[1–3] The Universal Declaration of Human Rights provides a legal framework for the Member States of the United Nations, supporting dignity as a fundamental human right. From a philosophical point of view, the earliest reference to the concept of dignity is found in the Ancient Greek and specifically in Aristotle's philosophy and Sophocles' tragedy 'Antigone' in which dignity was described as a moral virtue that should be preserved.[3] Aristotle supported that autonomy and rationality are the central characteristics of dignity, and that every human has the right to have his or her dignity maintained. Contemporary nursing philosophical accounts of dignity[4] also emphasised autonomy and described a range of dignity distinguished dimensions like intrinsic and attributed,[2,5] relational or absolute.[6] In a 'taxonomy of dignity', Jacobson differentiates between human dignity, that is dignity held by all people by virtue that they are human; and social dignity, that is generated in the interactions between and among individuals, collectives and societies.[7] According to the author, any human interaction can be dignity encounter 'an interaction in which dignity comes to the fore and is either promoted or violated'. Among the different varieties of dignity described, the one that is very much related to care is 'the identity dignity' that is tied to the body and mind integrity which could be removed when people are humiliated, insulted or treated as objects.[4,8,9] Some authors supported that dignity is a combined concept in which dignity is mainly a state of mind, suggesting the existence of two dimensions: (a) the absolute dignity related to human value, freedom and responsibility and (b) the relative dignity influenced by culture and undergoes continuous change throughout life.[6] It is also discussed that nurses need to possess dignity in order to maintain it for their patients, and that shared humanity is a vital component in nursing care.[10] In Jacelon et al.[2] concept analysis, three defining attributes of dignity were revealed: (a) dignity as a characteristic of human being, (b) as the subjective feeling of the self and (c) as an external behavioural component. The fact that dignity was evidenced through certain behaviours that demonstrate respect for self and others provides a basis on which an operational definition of the concept could be developed and nursing interventions towards the promotion of dignity could be formulated. Such a clarification would enable nurses to understand the meaning, facilitate the delivery of dignified care and assist nurse educators to teach students about the promotion of patients' dignity. That is also in line with the Royal College of Nursing declaration[11] that 'in care situations, dignity may be promoted or diminished by the physical environment, organisational culture, by the attitudes and behaviour of the nursing team and others and by the way in which care activities are carried out'.

However, patient dignity has been the subject of considerable debates especially after the publication – in England – of two important reports of public inquiry into patient care, that is the Care Quality Commission report on dignity and nutrition for older people[12] as well as the Francis Report[13] that challenged the quality and safety of patient care, raising concerns as to the ability of nurses to promote patient dignity.

### *Evidence*

Much of the empirical work reports patient's evidence of humiliation, poor communication, exclusion and insensitivity to their needs.[14,15] Typical examples of violation of patient dignity are given in the aforementioned reports such as 'patients privacy and dignity were not respected', and that 'large numbers of patients were left unprotected, exposed to risk, and subjected to quite unacceptable risks of harm and indignity over a period of years'. In some cases, dignity is related to privacy[16,17] and patients' views overlap in the way they define both concepts, suggesting some support for the view that privacy and dignity are interlinking concepts.[18] It also seems that patients understand privacy in terms of information privacy, privacy of body,

exerting control over ones care, gaining respect, having the right to be alone and having one's own personal space respected.[18]

In the United States,[2,19,20] it is consistently found that throughout the hospital stay dignity was continuously compromised. In the early stages of hospitalisation, threats to health were considered more important than those to dignity and the older people endured threats to dignity in favour of treating the health problem. In the later stages, however, the older people engaged in strategies to enhance dignity whenever the others' behaviour was inconsistent to their dignity definition. In addition, it was supported that nurses' measures to maintain patients' dignity were perceived as respect, protecting privacy, emotional support, treating all patients equally and maintaining body image.[21] In Australia, Walsh and Kowanko[22] found that nurses and patients attributed similar characteristics to dignity, including respect, privacy, control, time, choice and confidentiality, while in Asia nurses' and patients' views of dignity were significantly different[23] especially regarding the importance of patient's privacy and nurse–patient interaction. The work of Jacobson in Canada, based on a review of the literature and grounded theory analysis of the lived experience and key-informant interviews, resulted in the development of a general theory of dignity violation.[24] The author found that dignity violations in healthcare occur through the processes of rudeness, indifference, condescension, dismissal, disregard, dependence, restriction, discrimination, deprivation, assault and objection.

In other studies, although patients reported satisfaction with their care, they expressed strong feelings and mentioned several factors that have the potential to promote dignity, such as body privacy, personal hygiene, independence and the ability to exert control, sufficient time, attitudes and communication with staff.[25] Nurses shared similar views of dignity promotion, like approaching the patient as a unique entity, enhancing mobilisation and supporting patients' appearance.[26,27] Observational studies found that dignity may be influenced by the physical environment and the nurses' communication style.[28] Patients may possibly accept that the 'ideal practice' is not always provided because nurses are 'busy' with other issues in this environment. Similarly, studies exploring patients' privacy in intensive care units (ICUs) found that the application of routine interventions during the daily care was related to patients' body exposure and intimacy,[29] and incidents were recorded where patients have been observed totally naked or with their breasts or genitals uncovered.[30] Other authors support that the culture and the architectural structure of the ICUs contribute to the violation of privacy and patient dignity because these units are an open space, sometimes cramped, where patients of different sexes, ages and health conditions cohabit with family members and the professional team. Therefore, difficulties may arise regarding the integration of ethical and moral principles in daily clinical practice.[31] More recently, Tadd and Read[32] pointed out that failure to provide dignified care often resulted from systemic and organisational factors rather than individual failures of staff members, and that nurses are struggling to maintain patients' dignity.[33] At the same time, they have to deal with organisational constraints alongside with the moral conflict of what they are able and what they would like to deliver in the older people care.[34] In a focus group study by Baillie[16] aiming to explore nursing students experiences of caring for older people with dementia in hospitals, students reported that patients were not treated with respect or dignity. They also recognised important elements of dignity like person-centered approaches, individuality and respectful connections with patients. However, although patient dignity has been examined both from the perspective of patients and nurses, at least to the authors' knowledge, there is no published literature on nursing students' experiences and thoughts specifically on this issue. Nevertheless, the students can offer valuable information since they may value and interpret patient dignity differently as they have not yet become an active part of healthcare systems and decision-making.

## Aim

The study aimed to explore nursing students' perceptions on patients' dignity throughout their experiences during clinical practice.

## Method

### Design

A qualitative research approach via focus groups was employed to elicit responses from nursing students. That particular approach was selected as the most appropriate because answers and opinions can be expressed in depth[35,36] within a non-threatening environment[37] in which relations and reactions to each others' experiences create a synergy that individual interviews cannot offer.[35,36]

### Settings, sample and participants

Nursing students from a department of nursing of a Cyprus University were invited to participate in four distinct focus group discussions. The researchers recruited students through advertisements placed in the nursing laboratories. Students should have had at least one clinical placement. From those students who expressed interest in the first day, 36 were selected – through purposive sampling – and invited to participate. All students except two (N = 34) accepted the invitation. The purposive sampling technique was used in order to achieve the desired homogeneity and heterogeneity of the groups.[38] Each group was homogenous in terms of the year of study (Group 1 = 9 first-year students, Group 2 = 8 second-year students, Group 3 = 9 third-year students, Group 4 = 8 fourth-year students) and heterogeneous in terms of clinical practice in various wards. Mixture in one group of students coming from different years of studies was avoided as it was assumed that this could cause confusion during the discussions due to the different levels of prior clinical experience.

### Ethical considerations

The study design was guided by the procedural ethical standards described by Beauchamp and Childress.[39] The protocol was reviewed by the National Bioethics Committee. Participants were aware of the study objectives and their rights to refuse participation or withdraw from the study at any time. They were also a priori informed that the discussions would be tape-recorded and assured that their anonymity would be preserved. Tape recordings and transcripts were only used for the purposes of this study. No written consent was given by the students; participation in any group was considered as informed consent as this was explained to all students at the beginning of each discussion and verbally acknowledged by them.

### Data collection

The focus group discussions were coordinated by a moderator. The mean duration of the discussions was 90 min. Data collection was performed between May and June 2012. Each discussion was commenced with an introduction explaining the study objectives and the ground rules emphasising confidentiality and respect of opinion. A non-threatening environment was created in order to encourage students to express their views and facilitate interaction.[40] In order to preserve participants' anonymity, facilitate the analysis and clearly identify the frequency of reported themes, each participant was asked to state a pseudonym prior to any comment.

Prior to commencing the study, the facilitator and the research team had thorough discussions on how the focus groups would be moderated and a set of steps were agreed according to the relevant procedural guidelines.[40,41] Initially, participants were requested to provide a definition of dignity and thereafter to consider a patient whom they had recently cared for and believe that his or her dignity was either promoted or violated. After that, they were encouraged to describe their experiences in the clinical settings in terms of violation or promotion of the patients' dignity. The moderator facilitated the discussion with probing, clarification

seeking, but without interfering the dialogue. Field notes and non-verbal responses, members' dominance, the effect of significant group members and the participants' relationships with the group leader were also noted by an independent observer.[41] At the end of each session, a short summary was made by the moderator, allowing the verification of the issues raised.

### *Data analysis*

Analysis included transcription of audio-tapes as well as from in-depth examination of the participants' interactions, which were recorded by an observer and finally from field notes which were maintained. In order to facilitate the analysis process, immediate debriefing and discussions of the collected data were performed at the end of each session among the moderator, the observer and other research team.[40] Data were managed using content analysis to provide a range of systematic, rule-guided techniques in interpreting the informational contents.[42] Three investigators (G.E., E.P. and C.A.) independently performed data analysis following Webb and Kevern's[41] suggestion to increase reliability. Each transcript reviewed several times before starting data analysis by locating common words or phrases and coding them into themes relevant to the patients' dignity. Emerged themes were compared for relevance and any discrepancies were resolved following thorough discussion.

## Findings

Findings revealed certain factors that may negatively influence (threat) patients' dignity as a result of the intrapersonal contact between patients and nurses during the nursing care provision. These factors were categorised into five main themes: (a) patients' preferences, verbal abuse and regarding the patient as a unique person; (b) privacy and confidentiality; (c) loss of autonomy and need for help; (d) discrimination and (e) attribution and reciprocity. No issues on patients' dignity promotion were described.

### *Patients' preferences, verbal abuse and regarding a patient as a unique person*

A major theme that consistently emerged throughout focus groups was the right of patients' participation in their care. Beyond taking patients' preferences into account, students noted that nurses were failing to gain consent prior to invasive procedures or care and instead they were shouting at patients, meaning that students were able to recognise verbal abuse and possible mistreatment.

Nursing students acknowledged the importance of respecting the patients' preferences: 'you can do nothing to a patient's body unless he/she permits you to do so' (fourth-year student). An example of the violation of patient's preference was reflected the drawing of a blood specimen:

> ... the nurse failed to draw blood during her first attempt and the patient told her to ask somebody else to help. The nurse replied: you cannot judge me, let me do my job. She then made a second attempt against patient's will.

Another incidence noted by a second-year student was 'they went to draw blood from an old-blind lady and they pulled her arm without informing her what they intended to do'. A third-year nursing student commented that: 'the patient did not want to have a bed bath at that time, but the nurses started shouting: you must have a bath now'.

Students reported that dignity is maintained when patients are treated as unique entities. That is influenced by the way patients are addressed and by the nurses' behaviour. Participants described several cases of inappropriate way of addressing patients. Frequently, patients are addressed by their medical problem and bed number: 'where is the appendicitis? ... bring 6A for an X-ray' (third-year student), diminutive names like: '... Georgie or Uncle Georgie ...' (second-year student) '... granny, honey, sugar ...'. One

student emphasised that: 'when nurses refer to patients as numbers, I feel like being in prison ...'. Participants in the study agreed that patients should be called by their names: 'I cannot say 6A meaning a patient, patients have names and I have to use them the way they want me to use it' (fourth-year nursing student). Another interesting comment was offered by a student wondering: 'why nurses refer to women as patients on the maternity ward ... we have been taught that pregnancy and birth is not an illness?'

Based on their living experiences during their clinical placements, students were able to identify situations where patients' dignity was violated due to nurses' information omissions. A second-year participant said:

> This patient with a serious contagious disease had to be isolated in his room. Nobody had informed him of this. He went out of the room and the senior nurse started shouting at him in front of other patients and nurses. I felt really sorry for him.

Another student stated that 'a nurse had to give an intramuscular injection to a patient. She never informed the patient about the need for this. She ordered the patient, in an unprofessional way, to turn on the side to administer the injection'.

### *Privacy and confidentiality*

Maintaining privacy was considered by the majority of study participants as an integral part of preserving patients' dignity. However, they recognised that the privacy and confidentiality principles were usually violated and they described several cases where patient's privacy was underestimated: 'there were many cases when nurses did not draw the curtains, allowing other patients or even visitors to look at a naked patient having a bed bath' and 'nurses were coming in and out of the patient's room without even closing the door during the bed bath time'. A second-year student noted that: 'the patient's privacy was not protected when he had a urethral catheter inserted while the other patients on the ward looked on'.

Students argued that information privacy and confidentiality are important but observed confidential matters being discussed by nurses with auxiliary staff or other patients. 'The nurse was shouting ... I have inserted a catheter, you may pass urine now ... in a way that other patients and visitors were informed about this treatment' (third-year student).

### *Loss of autonomy and need for help*

Nursing students recognised that the need for help may threaten patient's dignity, and that dignity takes on a new meaning when a person becomes dependent on others. They explained that when patients are admitted to hospital they may feel dependent or unable for self-care: 'Patients may need to accept that nurses will provide care for them, something they used to do on their own prior to their admission ... for example the need to have help for a bath'. A fourth-year student argued that: '... patients have more comforts in their homes; but in the hospital they have to share the place'. It was suggested by many students that patients may feel important at home, but in hospital feelings are quite different. The fact that patients have to stay in a hospital, possibly confined to bed and dependent on others even for their basic needs, may lead them to 'feel incapable ... their dignity is threatened because the ability of self-care is limited'.

Medical diagnosis, the patients' condition and age, implying the contention of ageism, seemed also to influence dignity status: 'in a room with an 85 year old man with dementia and a young man, nurses didn't spend the same amount of time although they both needed help ... with the older person they spent only 5 minutes ...' (fourth-year student). Experiences of discrimination were mentioned for patients who were confused or aggressive: 'the patient's behaviour was above my personal limits ... his safety was in danger ... I needed to shout at him in order to understand ...'. This kind of behaviour, which may seem that, is for the benefit and safety of patients, at the end may lead to violation of their dignity. This was particularly

evident in mental health patients. A student practising in a mental health unit, describing how some patients were treated, said: 'I wanted to cry, to run away, I couldn't believe what was happening there ...'.

### *Discrimination*

Patients' nationality was considered by some students as a dignity threatening factor because nurses may be reluctant to care patients from different nationality: 'One nurse expected some other nurse to give this patient a bed bath. In the end nobody did'. A fourth-year student mentioned her experience of a patient verbally humiliated and when she asked nurse why she was shouting, she replied: 'he is a foreigner; he doesn't understand what we are saying ...'. Interestingly, a student talked about his feelings the first day in the hospital saying how his dignity was violated because 'everybody was whispering, how can I become a nurse with all those tattoos and earrings in my body'.

### *Attribution and reciprocity*

The dignity possession within self-concept was also considered as important antecedents of respecting other people's dignity. Students realised that in order to maintain patient's dignity, nurses need to 'respect themselves' (fourth-year student). Several experiences were expressed about their own dignity (or witnessed other nurses) being violated by other staff members, patients or relatives. The commonly expressed phrase was 'I need to feel dignity for myself in order to be able to promote dignity to other people'. There were many examples of students being humiliated by undignified behaviours of other nurses: 'the nurse told me to get out of the room, she didn't want me to work with her and she said that while the patients were watching' (third-year student). An additional astonishing comment was '... in our practising ward, I feel that I am invisible. They do not pay attention to me, they are just shouting when they need me for the vital signs assessment' (third-year student). In another case, one participant referred that the nurses' professional dignity is not recognised by physicians, patients or families: 'I have a professional responsibility to deliver dignified care, but at the same time I need to be respected as a person and a professional' (second-year student).

Nursing students suggested that younger nurses tend to respect patient's dignity more often than older ones: 'Younger nurses are more careful concerning the patients' privacy and dignity' (third-year students). Yet '... the curtains drawn during bed baths, I see younger nurses using them more often' (fourth-year student).

It was also recognised that dignity is a significant value and a challenge to be achieved because nurses are also human beings, working in demanding environments and dealing with their own personal problems. The nurses' personal moods or emotional states were mentioned as a determinant towards dignity promotions or violations: '... the nurse may not feel well that day ... it is not always possible to leave personal problems behind. This, may sometimes exhibit inappropriate behaviours to patients, threatening in this way dignity' (third-year student). On the other hand, there were opinions expressing that: 'it's not that nurses don't respect dignity ... they do not have time, or the number of nurses is so limited that they are paying attention to more important things ...'.

## Discussion

In this study, different understandings of the perceived concept of dignity and the factors that maintain or compromise patient's dignity were expressed through the eyes and the feelings of nursing students. Important elements within the students' meanings towards patients' dignity were pointed out on individualised care, privacy and confidentiality, attribution and reciprocity. It was also evidenced that nursing students

were able to recognise patients' vulnerability, the context of care delivery and conditions leading to patients' dignity violations such as limited autonomy, increased dependency and different nationality.

Another interesting finding of our study is that students persistently raised issues of violation of dignity and gave several examples instead of discussing any aspects of promotion of dignity. A possible explanation is because they felt the need to discuss their experiences and negative feelings of witnessing as well as being a part of the relation of asymmetry between nurses–patients and nurses–students. According to the general theory of dignity violation,[7] dignity encounters appear more likely to result in violation when one actor is in a position of vulnerability (e.g. sick, weak, helpless) and the other has more power, knowledge or strength than the other, especially in settings often characterised as hierarchical and rigid. In this case, violation may cause injuries to self-dignity, for example, identity, self respect, self-esteem, individuality and to dignity as related to autonomy and status. Therefore, students' experiences have revealed a combination of vulnerabilities, and that dignity of other actors in the hospital settings may be at risk, especially those at the bottoms who are often treated with disregard and indifference by their supervisors or coworkers.

Many of the participants' descriptions of the contributions to patients' dignity are grouped on the individualised care and supported by the theoretical and empirical literature.[4] In many cases, students marked nurses' reluctance to involve patients in the decision-making process regarding their care or accept their preferences. Such behaviours threaten patients' dignity as they may feel that they are excluded from decision-making, their opinion has no meaning and that nurses can do anything to them without their permission or participation. Instead, students' observations about nurses' failing to gain consent prior to certain care procedures and shouting to patients imply evidence of humiliation and poor communication and support previous findings.[14] However, these are different from the literature supporting that following patient's suggestions or preferences is crucial for the individualised care[43,44] and contribute to positive nursing care outcomes.[45]

Many students acknowledged that providing information to patients is a fundamental part of nursing care. That is in-line and supports previous studies contacted among patients[46–49] or it is perceived as a dignity threat when it was withheld.[50,51] In this study, nursing students described certain cases in which information was not properly provided, leading to patients' misunderstandings (e.g. the need to stay in the room). Thus, it could be assumed that nurses may believe that they can act as they consider is better without informing or asking patients. That may be the result of a perceived authoritative status of nurses over patients, which is inflated from the patients' needs and dependence and is in line with earlier findings.[52,53] It is not surprising that when patients are actually provided with information regarding their health status and treatment, they feel valued and respected with positive effects on satisfaction from nursing care.[54]

The way nurses address patients was described as a major issue of dignity respect. A number of cases stated that patients were called by alternatives rather their names. In some instances, patients were even addressed as their medical problem, leading to the assumption that either nurses do not know their patients' names or they consider them as individuals without a personal identity or they probably perceive them as an object with physical malfunctions. In previous studies, this kind of behaviour was also described as a violation of the patients' autonomy and dignity.[14,48] It is also in line with the social processes of dignity violation that seem to be the most common in healthcare settings described by Jacobson,[7] especially *rudeness and condescension*. In the first case, dignity is violated when nurses call people by their first names without first asking about their preferred form of address and in the case of condescension people feel their dignity is injured when they are spoken to like a child by health professionals. Dignity is also violated through the process of objectification, meaning that patients are treated like a thing, not a person because of the habit of referring to people by disease, procedure or room number instead of by name.

An additional agreement with the relevant theoretical literature was raised in the nursing care activities and their potential to promote or threat dignity, by respecting privacy and avoiding patients' exposure during bathing and toileting.[4] Unfortunately, students described cases of exposing patients' naked bodies

during bed baths. The marked body exposure as a result of nurses' omissions (e.g. non-use of curtains) has also been identified by patients as a dignity threatening factor.[54,55] Previous studies demonstrated that nurses acknowledged that protecting patients' privacy is an essential part of preserving their dignity,[56] and that dignity can be lost when bodily or other personal boundaries are transgressed.[7] It is therefore clear that nurses need to address this issue in a more sensitive and precise way in order to promote dignity and patients' satisfaction in a more comfortable and friendly hospital environment.[27]

Respecting confidentiality was highlighted as an additional determinant towards dignity promotion. Standards of nursing practice as well as legislation in many parts of the world clearly state that nurses (and healthcare professional in general) should preserve all information coming to their knowledge as a result of being part of the health system and the provision of nursing care.[57,58] Despite this, students identified that nurses' behaviour is not in accordance with that requirement and somehow failed to protect the patients' personal data by revealing them (intentionally or unintentionally).

Students recognised the vulnerability of some patients to dignity loss, supporting Baillie and Gallagher's[27] and Jacobson's[24] findings. The hospital environment and the care context may usually become unfriendly or uncomfortable for patients. Patients may need to compromise with certain institutional situations, for example, eating habits or waiting their turn to go to toilet. The encounters of the hospital like bed curtains that do not fully close, inability to lock the rooms where patients wash or use the toilet and the custom of mixing the sexes in some wards may all cause intrusion and threaten privacy.[24] Therefore, some patients may feel that they are being ignored or disrespected, a fact that may threaten their dignity perceptions. Besides, it was generally evidenced that admission to a hospital may cause serious emotional distress, especially when that admission is related to loss of autonomy and increased dependency. Nursing students of this study suggested that such situations could lead patients to feel incapable, and that their dignity is threaten, in support to the classical and contemporary philosophical accounts of the autonomy importance to certain aspects of dignity.[4]

Surprisingly, nursing students reported cases of nurses refusing or being reluctant to provide care to patients with different nationality. This finding is in accordance with a previous study among nurses in the same country, in which different nationality was considered as a positive influential factor for practising standard precautions.[59] Such perceptions, however, oppose the requirements of national and international ethical codes,[60] which clearly state that nursing care should be provided irrespective of (among others) patient's nationality.

The students' realisations of the reciprocal nature of dignity as well as the expressions of their lived experiences regarding the violation of their own dignity revealed another interesting finding; that should be considered a major issue for discussion and resolution among all those professionals involved in nurse education. This is particularly worrying and disturbing because nursing students could also be considered a vulnerable group struggling to adapt in a difficult and demanding professional environment. It is also evidenced that the dignity sensitivity and promotion as fundamental nursing values cannot merely be taught throughout the traditional methods. Dignity sensitivity and promotion could be gradually developed within the content of adequate dignity treatment received by others.[2] The nursing students' future behaviours, including dignity related, might be influenced by the environmental examples they received and by their own experiences (from nurses, patients or relatives) during their education and clinical practice.

The limitations of this study include the fact that the results cannot be generalised to the whole nursing students' population. It should be stated, however, that the authors' intention was to gain an initial in-depth look on the issue of patients' dignity from the nursing students' point of view, since this had not been previously studied. Future studies employing other methods can produce results that may be generalised to the studied population.[61] Every effort was made to include nursing students practising nursing in as many disciplines as possible, although this was not always possible. Finally, since this research was undertaken on the premises of the university at which participants are studying and researchers are teaching, this may have

possibly led to self-report bias from the students by trying to provide such information that – based on their opinion – could be desired by the research team.

## Conclusion

Students of nursing will be the future healthcare professionals and understanding their opinions by educators is considered more than important. Nursing curricula could be tailored accordingly in order to facilitate the promotion of respecting patients' dignity. The need for further examination towards the respect and the promotion of patients' dignity and its correlation with patients' outcomes is also addressed in this study. Such correlation is seemed crucial to convince nurses and mainly policy makers that maintaining patients' dignity will enhance the quality of nursing care as well as patients' satisfaction.

Journal reviewers invited the researchers to consider their responses to student reports of unethical practice. This is an important issue that raises ethical considerations both for students and those nurses reported to have failed practising ethically. In fact, this finding has raised concerns among the researchers. An interesting approach would be the one developed by the faculty of health sciences at the University of Southampton[62] where a support service for students is available in order for them to report any adverse events. Similar services can be organised throughout universities/colleges allowing nursing students to report any unethical practices and receive appropriate feedback and support. It is the researchers' intention to raise this issue in order to start dialogue among those involved in nursing education in Cyprus, to address this.

In addition, the researchers have prepared a short report to submit to the Director of Nursing Services in Cyprus. This report includes all relevant findings of this study; however, at this point, the researchers decided to avoid reporting specific details (e.g. names, wards) until further discussion with those involved (ward managers, hospital managers) has taken place and decisions have been made on how to make such reports.

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### Conflict of interest

The authors declare that there is no conflict of interest.

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